PRINTED: 07/18/2011 FORM APPROVED

	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155661	B. WING		06/17/2011
NAME OF I	PROVIDER OR SUPPLIEF	" }	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
			I -	HWY 46	
OWEN V	ALLEY HEALTH CA	AMPUS	SPENC	CER, IN47460	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000	The submission of this plan	of
	State Licensure		1.0000	correction does not indicate	•
	State Licensule	Survey.		admission by Owen Valley H	
	Cumus Datas I	une 13, 14, 15, 16, 17,		Campus (the facility) that the	
	2011	une 13, 14, 13, 10, 17,		findings and allegations cont herein are an accurate and t	•
	2011			representation of the quality	I
	D 11: N 1	010000		care and services provided t	•
	Facility Number			residents of Owen Valley He	
	Provider Numbe			Campus. This facility recogn	•
	AIM Number: 2	200229560		its obligation to provide legal and medically necessary car	
				and services to its residents	I
	Survey Team:			economic and efficient	
	Mary Weyls, RN			manner.The facility hereby	
	(June 13, 15, 16,			maintains it is in substantial	
	Teresa Buske, R	N		compliance with the requirer of participation for comprehe	•
	Laura Brashear,	RN		health care facilities(for title	18/19
	Census Bed Type	o·		programs). To this end, this p of correction shall serve as t	I
	SNF/NF: 99	С.		credible allegation of complia	I
	SNF: 4			with all state and federal	
	Total: 103			requirements governing the	
	101.103			management of this facility.	I
	C D T.			this submitted as matter of s only.	latue
	Census Payor Ty	pe.		,-	
	Medicare: 10				
	Medicaid: 73				
	Other: 20				
	Total: 103				
	Sample: 21				
	Supplemental S	ampla: Q			
	Supplemental S	ample. o			
	These deficienci	es also reflect state			

findings cited in accordance with 410 IAC LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

141611

Facility ID:

010892

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155661	B. WING		06/17/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
OWENIX	ALLEY HEALTH CA	AMDUS	l l	HWY 46 CER, IN47460	
				JER, 11147400	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	, and the second se	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION DATE
1110	16.2	Esc ibertii Tind in Oldmirion)	1710		DATE
	10.2				
	Onality raviany a	ampleted on June 22			
	2011 by Bev Fau	ompleted on June 23,			
	2011 by Bev Fau	likliel, KIN			
F0164	The resident has t	the right to personal privacy			
SS=D	-	of his or her personal and			
	clinical records.				
	Personal privacy i	ncludes accommodations,			
		, written and telephone			
		personal care, visits, and			
		and resident groups, but ire the facility to provide a			
	private room for ea				
	P				
		d in paragraph (e)(3) of this			
		ent may approve or refuse			
	any individual outs	sonal and clinical records to			
		nt to refuse release of			
	•	cal records does not apply			
		is transferred to another tion; or record release is			
	required by law.	1011, 01 100014 1010400 10			
	•	eep confidential all			
		ned in the resident's as of the form or storage			
		when release is required by			
	transfer to another	r healthcare institution; law;			
		nt contract; or the resident.			
		ation and record review,	F0164	what corrective actions will be accomplished for those	07/17/2011
		l to provide personal		residents found to have beer	,
	privacy to 1 of 4	residents reviewed in a		affected by the deficient	

l i '		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155661	B. WIN	G		06/17/2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
TVI WILL OF I	NO VIDER OR SOLITEIER			920 W I	HWY 46	
OWEN V	ALLEY HEALTH CA	MPUS		SPENC	ER, IN47460	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	sample of 21 observed receiving activities of daily living care. [Resident				practice:Resident #35 will be included in random audits	
					(attachment #2) conducted b	w
	#35]				DHS/Designee three times	' ^y
					weekly X 4 weeks to ensure	
	Finding includes:				resident privacy.how other	
					residents having the potentia	
	During initial tou	r with LPN # 10 on			be affected by the same defi-	
	"	a.m., Resident #35 was			practice will be identified and what corrective actions will be	I
		ng had a recent fall with			taken:All residents have the	e
					potential to be affected by	
		zed a Foley catheter. The			same alleged deficient practi	ce
	resident was obse	erved in bed.			therefore, through the systen	m
					changes statedbelow those	
		30 p.m., CNAs #5 and #6			residents will be ensured priv	
	were observed to	provide catheter care to			during care.Unit Manager ma rounds immediately to ensure	
	Resident #35. Th	ne resident was observed			privacy was unbreached for a	
	in bed with the pr	rivacy curtain not pulled			Health Care residents. No pr	
	around the reside	ent's bed. The resident			issues were found.During da	
	was observed to 1	be exposed from the			rounds Unit Manager will obs	serve
		. During the care, the			and/or interview at least	
	CNAs were obse				one resident for breach of pri issues. Unit Manager will	ivacy
		the care to wash their			document response on daily	
		e the resident exposed			round sheet.what measures	will
		g covering to the lower			be put into place or what sys	
	body.	ig covering to the lower			changes will be made to ens	
	body.				that the deficient practice doe not recur: A Mandatory in-ser	
	On 6/16/11 at 11.	20 a m. unan antanina			(attachment #1) will be condi	
		30 a.m., upon entering			with all nursing staff on Priva	
		m, CNAs #1 and #2 were			during care.During daily rour	nds
	l	g the resident to dress.			Unit Manager will observe ar	I
		observed sitting on the			interview at least one resider	
	-	partially dressed. The			breach of privacy issues. Uni Manager will document response	
	· ·	as not pulled around the			on daily round sheet (attachr	
	resident's bed. W	hile dressing the			#7).how the corrective action	
	resident, two ther	rapy staff were observed			be monitored to ensure the	
	to enter the reside	ent's room to assist with			deficient practice will not reci	ur, ie,

l ·		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155661		LDING	00	06/17/2	
		133001	B. WIN			00/17/2	011
NAME OF I	PROVIDER OR SUPPLIER			920 W H	DDRESS, CITY, STATE, ZIP CODE		
OWEN V	ALLEY HEALTH CA	MPUS		1	ER, IN47460		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	Minimum Data S completed on 6/9 as requiring exter for transfer. A facility policy Rights," dated 10 not limited to, "P Confidentiality: 1 personal privacy, includes privacy	h/11 at 10:25 a.m. A Set [MDS] assessment, h/11, coded the resident hsive assistance of two titled "Bill of Resident h/2004, included, but was			what quality assurance progr will be put into place:Randon audits (attachment #2) will be conducted per DHS/designed three times weekly X 4 week ensure resident privacy durin care.All audits, interviews an observations from the daily re sheets will be monitored and trended for compliance during monthly QA meetings minimum of 6 months or unt issue resolved.	n e e s to g d ound	

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		(X2) MULT A. BUILDI B. WING		00	(X3) DATE S COMPL 06/17/2	ETED	
	PROVIDER OR SUPPLIER		9	20 W H	DDRESS, CITY, STATE, ZIP CODE WY 46 ER, IN47460		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	PRI	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	(X5) COMPLETION
F0225 SS=D	The facility must in have been found or mistreating resistance had a finding nurse aide registry mistreatment of resistance of their property; a has of actions by a employee, which is service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including in and misappropriate reported immediate the facility and to with State law through (including to the Sagency). The facility must have alleged violations and must prevent the investigation is the reported to the addrepresentative and accordance with State survey and working days of the state survey and working the state of the s	nvestigations must be ministrator or his designated to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective		AG	DEFICIENCY)		DATE
	Based on record facility failed to allegations of mi residents reviewe	review and interview, the protect residents with streatment for 2 of 2 ed with concerns of m a CNA in a target	F022	5	what corrective actions will b accomplished for those resid found to have been affected the deficient practice: CNA #9 was suspended on 5/25/2011 pending an	ents	07/17/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

141611

Facility ID:

010892

If continuation sheet

Page 5 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155661	B. WIN			06/17/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	HWY 46		
OWFN V	ALLEY HEALTH CA	AMPUS		1	ER, IN47460		
							710
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1710	+	esident #33 alleged CNA		1110	investigation and was termin	ated	DATE
	1 -	_			5/31/2011	1.04	
	#9 touched her breast and Resident #104				Residents #33 and #104 was	3	
	1 -	asked her embarrassing			immediately assessed per		
	questions and ma				interview by Charge Nurse.		
	1	and the CNA was allowed			residents stated they were no		
	1 1	ility until the end of the			afraid they found his question strange and made them feel	iis	
	CNA's shift and	entered the resident's			uneasy and requested he no		
	room after they	voiced their concerns.			longer provide care to them.		
	(Resident #'s 33	and 104) (CNA#9)			Social Service Director		
					interviewed resident #33 and	ا ا	
	Findings include	::			#104 on 5/26/11 and at that time resid	lont	
	Thamso morado.				#33 stated she was fearful	ieni	
	During review o	f a "Fax / Incident			because her roommate resid	ent	
	1	d by the Administrator on			#104 was discharging and sl		
	1	n., documentation			was afraid to be alone at nig		
		5/11 "at approximately			CNA#9 was working that hal		
		**			Social Service Director reass resident#33 that CNA#9 wou		
	1 -	residents (Resident #'s 33			longer be providing care.	iiu iio	
	1 '	complaints of feeling			Resident was calmer. Reside	ent	
		vith statements made by			#104 had no fears but was		
		ocumentation indicated			apprhensive for her roomma		
	1	04 "reported that during a			Social Service Director reass	sured	
	Code Black situa	ation after the CNA was			resident #104 that CNA #33 would not be providing care.		
	instructed that sh	ne and [Resident #33] did			Member of Nursing Manager	ment	
	not want him car	ring for them, the CNA			team interviewed five alert a		
	kept bothering h	er"			oriented residents were		
	Under the title of	f "Immediate Action			interviewed to determine if the	· 1	
	Taken" documen	ntation indicated, but was			had any negative interaction	s with	
		nitially both residents			CNA#9. how other residents having t	he	
	denied being afraid of the employee and requested to just ask the [CNA] not to come into their room or care for them. [CNA#9] was immediately informed of				potential to be affected by th		
					same deficient practice will b		
					identified and what corrective		
					actions will be taken:		
	1 * 1				All residents have the potent		
		observed around the two			be affected by the same alleged deficient practice therefore	yea	
	residents or their	room."			denoient practice therefore		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155661 06/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 920 W HWY 46 OWEN VALLEY HEALTH CAMPUS SPENCER, IN47460 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE through the systemic changes stated below will ensure the During review of a campus will provide a safe "Complaints/Investigation related to environment. [CNA #9]" provided by the Administrator what measures will be put into on 6/17/11 at 10 a.m., documentation place or what systemic changes will be made to ensure that the indicated "On 5/25/11 at approximately deficient practice does not recur: 5:30 p.m.," two residents (#33 and 104) Director of Health Services will be voiced a concern to employee [LPN #3], re-educated on Abuse Policy and concerning CNA #9. The documentation Procedure (attachment #3) per Executive Director. indicated CNA #9 had been asking weird Social Service/Designee will questions and would stand looking around interview a minmum of two alert room. The documentation indicated the and oriented residents per week x "questions made Resident #104 uneasy." 6 months during resident first meetings to ensure residents The documentation indicated Resident have no concerns regarding #33 "complained that she was walking out negatrive interactions with of the bathroom and he came up behind nursing staff. Social Service Director/designee will chart her and grabbed her breast, when asked response about how he grabbed her breast she of these residents on Resident stated he had gone to help her and he First Notes and fill out resident rubbed up against her breast. Neither lady concern form and give to DHS. stated that they were afraid of the Any negative responses will be reported immediately to employee but did request that he not work ED/Designee for immediate with them any longer. [Resident #104] follow-up. Follow-up will be also requested that her money, credit card documented on Resident and debit card be secured in the DHS Concern Form. how the corrective actions will be (Director of Health Services) office as the monitored to ensure the deficient business office was closed. All items practice will not recur, ie, what were secured in the presence of the DHS quality assurance program will be and LPN #3. [CNA #9] was immediately put into place: All facility staff will be in-serviced informed, by [LPN #3] of the request and on the facility's Abuse and informed him that he was to not go into Neglect Policy and Procedure the resident room and that care for the two (attachment #3) upon hire and ladies would need to be done by another twice vear **Divisional Clinical Support Nurse** [CNA]. [CNA#9] voiced

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

141611

Facility ID:

010892

If continuation sheet

Page 7 of 27

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

Selection Sele	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
STRIET ADDRESS, CITY, STATE, APPCIDE OWEN VALLEY HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEPICIENCITS TAG REGILATORY OF ITS CENTRIFYING INFORMATION; Understanding" During interview of 1.PN #3 on 6/17/11 at 10.55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN indicated their essidents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident#33's breast, had asked several questions of Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104. LPN #3 indicated Resident #104 which made because he was looking around the room, and requested the LPN to take her money, credit card and debit card to look up. LPN #3 indicated she took Resident #104's money and eards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated the first indicated the first indicated the CNA worked the resident #33 and 104's room. The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated of Resident #33 on the last indicated the last indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated the CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.).	ANDILAN	or conduction				00		
OWEN VALLEY HEALTH CAMPUS IN SUMMARY SYNTAMINY OF DEPICINCES PRIETY TAG INCREMENTATION OF LOCATION OF LOCATION IN PURCEIBED BY FULL TAG IN DURIng interview of LPN #3 on 6/17/11 at 10.55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident #104. LPN #3 indicated he had a 5 gallon bucket enema for Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to look up. LPN #3 indicated she took Resident #104's money and cards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). During interview of Resident #33 on			1.00001	B. WIN		DDDESS CITY STATE ZIRCODE	""	
OWEN VALLEY HEALTH CAMPUS IXVII D SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Understanding" Understanding" During interview of LPN #3 on 6/17/11 at 10.55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident #104 which made both residents uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to lock up. LPN #3 indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated the cTNA #9 to take her money, credit card and debit card to lock up. LPN #3 indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated CNA #9s scheduled shift is from 6 a.m., until 6:30 p.m.). The LPN indicated CNA #9s scheduled shift is from 6 a.m., until 6:30 p.m. During interview of Resident #33 on	NAME OF I	PROVIDER OR SUPPLIEF	R					
REGULATORY OR LSC IDENTIFYING INFORMATION) understanding" During interview of LPN #3 on 6/17/11 at 10:55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN entered Resident's #33 and 104's room to deliver their supper tray. The LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident#3*15 breast, had asked several questions of Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104. LPN #3 indicated Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to lock up. LPN #3 indicated she was instructed to tell CNA #9 to stay out of Resident #104 CNA #9 to stay out of Resident #104 CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m.). During interview of Resident #33 on	OWEN V	ALLEY HEALTH CA	AMPUS		1			
understanding" During interview of LPN #3 on 6/17/11 at 10:55 a.m., the LPN indicated that on 5/23/11, approximately around 5:30 p.m., the LPN entered Resident's #33 and 104's room to deliver their supper tray. The LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104. LPN #3 indicated Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to look up. LPN #3 indicated she took Resident #104's money and cards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m. During interview of Resident #33 on						PROVIDER'S PLAN OF CORRECTION		
understanding" During interview of LPN #3 on 6/17/11 at 10:55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN entered Resident's #33 and 104's room to deliver their supper tray. The LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to look up. LPN #3 indicated she took Resident #104's money and eards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m. During interview of Resident #33 on		•				CROSS-REFERENCED TO THE APPROPRIATE	ΤE	
During interview of LPN #3 on 6/17/11 at 10.55 a.m., the LPN indicated that on 5/25/11, approximately around 5:30 p.m., the LPN entered Resident's #33 and 104's room to deliver their supper tray. The LPN indicated the residents had voiced concerns about CNA #9. The concerns were that the CNA had touched Resident #33's breast, had asked several questions of Resident #104 which made both residents uncomfortable and had indicated he had a 5 gallon bucket enema for Resident #104 was uncomfortable because he was looking around the room, and requested the LPN to take her money, credit card and debit card to lock up. LPN #3 indicated she took Resident #104's money and cards to the DNS's (Director of Nursing Service) office and reported to the DNS the residents concerns. The LPN indicated she was instructed to tell CNA #9 to stay out of Resident #33 and 104's room. The LPN indicated the CNA worked the rest of his shift (until 6:30 p.m.). The LPN indicated CNA #9's scheduled shift is from 6 a.m., until 6:30 p.m. During interview of Resident #33 on	TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
During interview of Resident #33 on	TAG	understanding During interview 10:55 a.m., the I 5/25/11, approxithe LPN entered room to deliver to LPN indicated the concerns about 0 were that the CN Resident#33's brought questions of Resident #10 Resident #10 Resident #10 Resident #104 who because he was land requested the credit card and define #3 indicated she money and cards of Nursing Servithe DNS the resident was a formal to the power of the LPN worked the rest of p.m.). The LPN scheduled shift in	y of LPN #3 on 6/17/11 at LPN indicated that on mately around 5:30 p.m., Resident's #33 and 104's their supper tray. The ne residents had voiced CNA #9. The concerns IA had touched teast, had asked several ident #104 which made neomfortable and had a 5 gallon bucket enema 4. LPN #3 indicated tooking around the room, the LPN to take her money, the LPN took Resident #104's to the DNS's (Director ce) office and reported to dents concerns. The LPN is instructed to tell CNA Resident #33 and 104's indicated the CNA of his shift (until 6:30 indicated CNA #9's		TAG	will be notified immediately be ED/DHS of any allegations of abuse so that she/he may review to ensure compliance facility's Abuse and Neglect and Procedure. ED/Designee will review all resident Concern forms a monthly QA meeting for a minimum of 6 months or until	of of Policy	DATE
		. ₁ ,						
		During interview	v of Resident #33 on					
		_						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 14I611

Facility ID:

010892

If continuation sheet

Page 8 of 27

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155661	A. BUII	LDING	00	06/17/20	
		133001	B. WIN			00/17/20	711
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HWY 46		
OWEN V	ALLEY HEALTH CA	MPUS			ER, IN47460		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		I her roommate had a					
		A #9. The resident					
	· ·	the incident happened					
	-	ne facility was under a					
		and the residents had					
	-	ncerns to the nurse prior					
		arning. The resident					
		s in the bathroom and					
	•	he bathroom door					
	_	g, the resident indicated it					
		she was dressed. The					
		d the CNA #9 was					
	_	of the bathroom while					
	_	her walker and he					
		st. The resident indicated					
		could have kept his					
		e resident indicated that					
	•	'NA #9 asked her					
	,	lent #104) a lot of silly					
	•	s if [Resident 104] had					
ı	,	ne ever acted like a frog					
		toilet. Resident #33 also					
		9 made a comment to					
		oout having a 5 gallon					
		r her. The resident					
		l her roommate told LPN					
		dents and ask that the					
		wed to come back into					
		resident indicated that					
		e incident, CNA #9 came					
	back to their roor						
	apologize to then	n.					
	During interview	of the Administrator on					
	Laining interview	or morramination on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

141611

Facility ID:

010892

If continuation sheet

Page 9 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SU COMPLE			
		155661	A. BUI B. WIN	LDING		06/17/20		
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				HWY 46			
	ALLEY HEALTH CA			SPENCER, IN47460				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	Dia lettike 1)		DATE	
	1	, the Administrator						
		ility had implemented a						
	_	procedure on 5/25/11						
	around 6 p.m. Th							
		9 should have been						
		n LPN #3 brought the						
	resident's allegati	ions to the DNS.						
	Upon review of (CNA #9's time sheet,						
	1 ^	/11 at 11:10 a.m., from						
		N, documentation						
		A clocked out at 6:32						
	p.m.	11 0100R0d out at 0.32						
	p.iii.							
	Resident #33's cl	inical record was						
	reviewed on 6/17	7/11 at 11:20 a.m.						
	An initial assessr	ment, dated 4/30/11,						
	indicated the resi	dent was cognitively						
	intact and the res	ident required assist of						
	one with transfer	s, ambulation and						
	dressing.							
	Resident #104's	discharged clinical record						
	was reviewed on	6/17/11 at 12:45 p.m.						
		ecord indicated the						
	resident was adm	nitted on 2/29/11 and						
	discharged on 5/2	27/11.						
	An initial assessr	nent was noted, dated						
	5/6/11, indicated							
	· ·	t and required assist with						
		living (ADL) due to a						
	activity's of daily	nving (ADL) due to a						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155661	A. BUII			06/17/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/11/2	
NAME OF I	PROVIDER OR SUPPLIER			920 W F			
OWEN V	ALLEY HEALTH CA	MPUS			ER, IN47460		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	recent fracture rig			IAG			DATE
	3.1-28(d)						
F0226 SS=D	written policies and mistreatment, negl and misappropriati	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.	EO	226	what corrective actions will be	Q	07/17/2011
	facility failed to for procedure concerns for 2 of concerns of mistrin a target sample was allowed to stroncerns were votand the CNA in or residents room. (Resident #104) Findings include: During review of Report" provided 6/17/11 at 10 a.m. indicated on 5/25 5:30 p.m.," two reand 104) voiced of uncomfortable w CNA #9. The dothat Resident #10 Code Black situa	reatment from CNA #9 e of 21 in that the CNA ray in the facility after the viced to a staff person, question re-entered the Resident #33 and Ta "Fax / Incident by the Administrator on	F0	226	what corrective actions will be accomplished for those resided to the deficient practice: CNA #8 suspended on 5/25/2011 and terminated 5/31/11 Residents and #104 was immediately assessed per interview by Ch Nurse. Both residents stated were not afraid they found his questions strange and made them feel uneasy and requested he no longer provide care to them. Social Service Director interviewed resident #33 and #104 on 5/26/11 and at that the resident #33 stated she was fearful because her roommat resident #104 was discharging and she was afraid to be alon night if CNA#9 was working the hall. Social Service Director reassured resident #33 that CNA#9 would no longer be providing care. Resident #104 had not fears but was apprhensive for roommate, Social Service Director reassured resident # that CNA #33 would not be providing care. Member of	ents by 0 was 4 was 4 was arage I they s sted ime ag ne at chat	07/17/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

141611

Facility ID:

010892

If continuation sheet

Page 11 of 27

l '		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155661	B. WIN	G		06/17/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
TWINE OF I	NO VIDEN ON SOIT EIEN			1	HWY 46	
OWEN V	ALLEY HEALTH CA	MPUS		SPENC	CER, IN47460	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ing for them, the CNA			Nursing Management team interviewed five alert and ori	anta d
	kept bothering he	er"			residents were interviewed to	
	Under the title of	"Immediate Action			determine if they had any	٦
	Taken" documen	tation indicated, but was			negative interactions with	
	not limited to, "In	nitially both residents			CNA#9.how other residents	
	l	id of the employee and			having the potential to be aff	
		ask the [CNA] not to			by the same deficient practic	I
	1 1	oom or care for them.			be identified and what correct actions will be taken:All residuals	
		mediately informed of			have the potential to be affect	
		•			by the same alleged deficier	I
		observed around the two			practice therefore through	
	residents or their	room."			systemic changes stated be	ow
					will ensure the campus will	
	During review of				provide a safe environmenty	I
	"Complaints/Inve	estigation related to			measures will be put into pla	I
	[CNA #9]" provi	ded by the Administrator			what systemic changes will I made to ensure that the defi	
	on 6/17/11 at 10 a	a.m., documentation			practice does not recur: Dire	I
	indicated "On 5/2	25/11 at approximately			of Health Services will be	
		esidents (#33 and 104)			re-educated on Abuse and	
		to employee [LPN #3],			Neglect Policy and	
		#9. The documentation			Procedure (attachment #3) p Executive Director.Social	per
	_	9 had been asking weird			Service/Designee will intervi	ew a
		_			minmum of two alert and original	
	l -	ould stand looking around mentation indicated the			residents per week x 6	
					months during resident first	
		Resident #104 uneasy."			meetings to ensure residents	5
		on indicated Resident			have no concerns regarding	
	_	that she was walking out			negatrive interactions with nursing staff. Social Service	
		and he came up behind			Director/designee will chart	
	her and grabbed l	her breast, when asked			responseof these residents	on
	about how he gra	bbed her breast she			Resident First Notes and fill	
	stated he had gon	e to help her and he			out resident concern form ar	nd
	· ·	t her breast. Neither lady			give to DHS. Any negative	
	stated that they w				responses will be reported immediately to ED/Designee	for
	1	request that he not work			immediate follow-up. Follow	I
		nger. [Resident #104]			will be documented on Resid	
	with them ally 10	11501. [Resident #104]				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAIN	OF CORRECTION	155661	- 1	LDING	00	06/17/2	
		133001	B. WIN			00/17/2	011
NAME OF	PROVIDER OR SUPPLIEF	2		1	ADDRESS, CITY, STATE, ZIP CODE HWY 46		
OWEN \	/ALLEY HEALTH CA	AMPUS	SPENCER, IN47460				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	-4:	DATE
		nat her money, credit card			Concern Form.how the corre actions will be monitored to	ctive	
		e secured in the DHS			ensure the deficient practice	will	
	1 '	lth Services) office as the			not recur, ie, what quality		
		vas closed. All items			assurance program will be p		
		the presence of the DHS			into place:All facility staff will		
	1	NA #9] was immediately			in-sevice on the facility's Abu and Neglect Policy and Proc		
		PN #3] of the request and			(attachment #3) upon hire ar		
	1	at he was to not go into			twice yearlyDivisional Clinica	ıl	
	the resident room	n and that care for the two			Support Nurse will be notified		
	ladies would nee	ed to be done by another			immediately by ED/DHS of a allegations of abuse so that	n	
	[CNA]. [CNA #9] voiced understanding"				she/he may review to ensure	•	
					compliance of facility's Abuse		
					Neglect Policy and		
	During interview	v of LPN #3, on 6/17/11			ProcedureED/Designee will review all resident Conce		
	at 10:55 a.m., the	e LPN indicated that on					
	5/25/11, approxi	mately around 5:30 p.m.,		forms at monthly QA meeting for a minimum of 6 months or until		-	
	the LPN entered	Resident's #33 and 104's			issues resolved.		
	room to deliver t	their supper tray. The					
	1	ne residents had voiced					
	concerns about (CNA #9. The concerns					
		JA had touched Resident					
		asked several questions					
	1	which made both					
		fortable and had indicated					
		n bucket enema for					
	1	PN #3 indicated Resident					
		nfortable because he was					
		he room, and requested					
	1	her money, credit card					
	1	lock up. LPN #3					
	1	ok Resident #104's money					
		DNS's (Director of					
		office and reported to					
	1 -	_					
	the DNS the resi	dents concerns. The LPN					

010892

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155661		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/20	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF	PROVIDER OR SUPPLIEI	₹			HWY 46		
	/ALLEY HEALTH C			SPENC	ER, IN47460		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG	•	as instructed to tell CNA	+	IAU	,		DATE
		Resident #33 and 104's					
	1	indicated the CNA					
		of his shift (until 6:30					
		indicated CNA #9's					
	1 * '	s from 6 a.m., until 6:30					
	p.m.	o mom o willing willing one o					
	During interview	v of Resident #33 on					
	6/17/11 at 11:20	p.m., the resident					
	indicated she and	d her roommate had a					
	concern with CN	JA #9. The resident					
	indicated the tim	ne frame to be on the day					
	the facility was i	ander a tornado warning.					
	The resident ind	icated she was in the					
	bathroom and C	NA#9 opened the					
	bathroom door v	vithout knocking, the					
	resident indicate	d it was a good thing she					
	was dressed. Th	e resident indicated the					
	1	isting her out of the					
	1	she was utilizing her					
		uched her breast. The					
		d she felt the CNA could					
	1 -	nds lower. The resident					
	1	me morning, CNA #9					
		nate (Resident #104) a lot					
		s such as if [Resident					
		mers, if she ever acted					
	1	ank out of a toilet.					
		o indicated CNA #9 made					
		esident #104 about having					
	1 -	t enema for her. The					
	resident indicate	d she and her roommate					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155661	A. BUII B. WIN			06/17/2011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L Comment			HWY 46	
OWENIN	/ALLEV HEALTH CA	MDLIC		1		
OVVEN V	'ALLEY HEALTH CA	AIVIPUS		SPENC	ER, IN47460	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	X (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	told LPN #3 abo	ut the incidents and asked				
	that the CNA not	t be allowed to come back				
		The resident indicated				
		ng the incident, CNA#9				
	_	ir room three times to				
	apologize to ther	n.				
	During interview	of the Administrator on				
	6/17/11 at 1 p.m.	, the Administrator				
	indicated the fac	ility had implemented a				
		procedure on 5/25/11				
	around 6 p.m. T	-				
	1 *	9 should have been				
		n LPN #3 brought the				
	residents' allegat	ions to the DNS.				
	11	CNIA //Ola diama ala ad				
	l *	CNA #9's time sheet,				
		/11 at 11:10 a.m., from				
	the Corporate RN	N, documentation				
	indicated the CN	A clocked out at 6:32				
	p.m.					
	Resident #33's cl	linical record was				
	reviewed on 6/17	7/11 at 11:20 a.m.				
	An initial access	ment, dated 4/30/11,				
		ident was cognitively				
		sident required assist of				
		rs, ambulation and				
	dressing.					
	Resident #104's	discharged clinical record				
	was reviewed on	6/17/11 at 12:45 p.m.				

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155661			A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/2	ETED
		133001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/17/2	011
NAME OF F	PROVIDER OR SUPPLIER			920 W H			
	ALLEY HEALTH CA			L	ER, IN47460		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	The admission regresident was admidischarged on 5/2 An initial assessr 5/6/11, indicated cognitively intact activity's of daily recent fracture right During review of "ABUSE AND Note 6/13/11 at 1:30 p. Administrator, do under the heading "Upon identification or neglect, immesafety of the residence of the reside	ecord indicated the nitted on 2/29/11 and 27/11. ment was noted, dated the resident was t and required assist with viving (ADL) due to a ght humerus. If a facility policy titled, NEGLECT" received on .m., from the ocumentation indicated g of "Protection" of tion of suspected abuse diately provide for the dent and the person nain anonymity as ecessary. This may of limited to the iii. Providing 1:1 oppopriate iv. Suspend yee(s) pending outcome					
F0282 SS=D	facility must be pro	ided or arranged by the ovided by qualified persons n each resident's written					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155661 06/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 920 W HWY 46 OWEN VALLEY HEALTH CAMPUS SPENCER, IN47460 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on observation, record review and F0282 what corrective actions will be 07/17/2011 accomplished for those residents interview, the facility failed to ensure found to have been affected by services were provided in accordance with the deficient practice:Resident each resident's plan of care in that 1 of 2 #60 side-rails were padded immediately per care plan for residents with plans of care to pad side seizure precautions. All residents rails were observed not to have the side with seizure precautions had rails padded in a sample of 21. (Resident careplans reviewed with in 24 #60) hours to ensure services were provided according to established care plan.how other residents Findings include: having the potential to be affected by the same deficient practice will 1. On 6/13/11 at 11:15 a.m., Resident be identified and what corrective #60's bed was observed not to have the actions will be taken: All residents have the potential to be affected 1/2 side rails padded. On 6/15/11 at 10:30 by the alleged deficient practice, a.m., 2:55 p.m. and 4 p.m., the 1/2 side therefore, the systemic changes rails were observed not to be padded on stated below will ensure campus Resident #60's bed. On 6/16/11 at 10:30 will provide a safe environment.what measures will a.m., the 1/2 side rails on Resident #60's be put into place or what systemic bed were observed not to be padded. changes will be made to ensure that the deficient practice does Interview of the Director of Health not recur: Unit Manager/Designee will audit (attachment Services (DHS) on 6/16/11 at 4 p.m., #2) residents having padded indicated the resident's side rails should side-rails during daily rounds have been padded. 3 times weekly x 4 weeks to ensure compliance with care plan.how the corrective actions Review of the clinical record of Resident will be monitored to ensure the #60 on 6/14/11 at 11:20 a.m., included a deficient practice will not plan of care addressing the problem of at recur:MDS will audit and update risk for fall/injury as exhibited by history resident care plans quarterly to ensure resident care-plan are of falls and potential for fall dated 3/7/10 accurate and interventions are and revised 4/11. The approached appropriate. Audits will be included but were not limited to 1/2 side reviewed monthly for a minimum rails as enabler and padded for seizure of six months during QA committee meeting or until precaution.

141611

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING B. WING 00			ETED	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	•	
_	ALLEY HEALTH CA			920 W H	ER, IN47460		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	non-compliant issue resolved	1	DATE
	3.1-35(g)(2)				non-compilant issue resolved	.	
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infectinormal bladder fur Based on observate record review, the and position indute to prevent urinary 3 residents review urinary catheters [Residents #34, #Findings include 1. During initial a.m., with LPN # observed in bed weatheter. The tubin contact with the On 6/14/11 at 9:5 observed in bed a was observed in enterties.	ation, interview and e facility failed to secure, velling urinary catheters y tract infections for 3 of wed with indwelling in a sample of 21. 435, and #53] tour on 6/13/11 at 11:50 f10 Resident #35 was with an indwelling Foley bing was observed to be	F03	315	what corrective actions will be accomplished for those reside found to have been affected the deficient practice: DHS/Designee will coached and re-educated LP #10, CNA's #5,1,2 on Guideli for Urinary Catheter Care . Residents #34, 35 and 53 wincluded in random audits(attachment #2) conduby the ADHS/Designee 3 time weekly x4 weeks to ensure proper placement and positioning of urinary cathete and catheter tubing as per fapolicy and procedure. Reside #34, 35 and 53 were assess and found to be free at this tion of Signs/symptons of UTI. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents.	ents by PN ines ill be cted es cr bag acility nt's sed me w e	07/17/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155661	B. WIN			06/17/2	011
NAME OF	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
WHILE OF	I KO VIDEK OK SOI I EIEI			920 W H	HWY 46		
	/ALLEY HEALTH CA			<u> </u>	ER, IN47460		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG		toro	DATE
		provide catheter care to			in the facility with foley cathe have the potential to be affect		
		he catheter was observed			by the alleged deficient	ica	
	1	d to the resident to prevent			practice.ADHS/Designee will		
	friction to the in:	sertion site. The drainage			conduct random audits		
	tubing was obser	rved to be in contact with			(attachment #2) 3 times wee	-	
	the floor during	the resident's care. CNA			x4 weeks to ensure residents		
	#5 asked if the to	ubing should go over or			with foley catheters have propleted placement of Urinary cathete		
	1	nt's leg and indicated she			bags and catheter tubing.wh		
	needed to look tl	-			measures will be put into pla		
		1			what systemic changes will t		
	On 6/16/11 at 11	:30 a.m., upon entering			made to ensure that the defi	cient	
		om, CNAs #1 and #2 were			practive does not recur:A		
		ssisting the resident to			mandatory in-service will be conducted for all nursing sta	ff on	
	1	_			Guidelines for Urinary Cathe		
		ent was observed sitting			care (attachment		
	1	ne bed and the Foley			#4). ADHS/Designee will cor		
	1	and drainage bag were			random audits (attachment #	2) 3	
	stretched out on	the floor.			times weekly x4 weeks to		
					ensure residents with foley catheters have proper placer	ment	
	On 6/16/11 at 5::	30 p.m., the resident was			of Urinary Catheter bags and		
	observed seated	in a wheelchair in the			Catheter tubing.how the		
	main dining room	m. The urinary drainage			corrective actions wll be		
	tubing was obser	rved in contact with the			monitored to ensure the defi-	cient	
	floor.				practice will recur:All audits	-	
					conducted on Foley Cathete Care will be monitored in QA		
	Resident #35's c	linical record was			committee meeting monthly		
		4/11 at 10:25 a.m. The			weeks or until non-complian		
		imum Data Set [MDS]			issue resolved. ADHS/Desig		
		pleted on 6/9/11, coded			will review and trend monthly		
	1	on-ambulatory, required			infection control logs for UTI' residents with foley catheters		
	1				ADHS/Designee will report	.	
		nce of two for bed			findings at monthly QA meet	ing x	
	1 -	nsfers and utilized an			6 months.	J	
	indwelling Foley	catheter.					
	2. On 6/13/11 w	vith LPN #10, which					

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 7/2011
PROVIDER OR SUPPLIER		B. WIIN	STREET A	DDRESS, CITY, STATE, ZIP C HWY 46 ER, IN47460	CODE	
SUMMARY S (EACH DEFICIEN REGULATORY OR began at 11:50 a. observed in bed and with an indw On 6/14/11 at 11 observed in bed araised position at tubing, containing over the top of the reviewed on 6/15 of care, dated 11, problem of Alter Elimination as excatheter, dated 6, included, but we "Maintain F/C [F by MD [medical shift, check pater	MPUS TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) m. Resident #53 was with two full side rails relling Foley Catheter. :00 a.m., the resident was with the side rails in the nd the catheter drainage g urine, was observed ne side rail. inical record was 5/11 at 10:45 a.m. A plan /24/10, addressed the ation in Urinary ridenced by indwelling /1/11. Interventions re not limited to Foley catheter] as ordered doctor] Cath care every ncy F/C every shift."	B. WIN	STREET A	HWY 46	CODE RRECTION SHOULD BE	(X5) COMPLETION DATE
LPN #10, which Resident #34 wa hemodialysis. On 6/15/11 at 12 observed in a wh Dining Room du drainage catheter under the seat of	uring initial tour with began at 11:50 a.m., s identified as being on :45 p.m., the resident was eelchair in the Main ring lunch. The urinary was observed positioned the chair and the was observed to be in floor.					

Facility ID:

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	155661	- 1	LDING	00	06/17/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			920 W F			
OWEN V	ALLEY HEALTH CA	MPUS		1	ER, IN47460		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION DATE
IAG			+	IAG			DATE
		30 p.m., the resident was Main Dining Room					
		r meal, seated in the					
		with the urinary drainage					
	tubing in contact						
	taoing in contact	with the moon.					
	Resident #34's cl	inical record was					
	reviewed on 6/16	6/11 at 12:05 p.m. An					
	admission date w	vas noted of 6/10/11. A					
	plan of care addr	essed alteration in					
	urinary eliminati	on as evidenced by					
	indwelling cathet	ter. Interventions					
	included, but we	re not limited to, "Change					
	foley catheter per	r physician orders. Keep					
	foley tubing free	of kinks and avoid					
	tension on urinar	y meatus. Provide					
		h soap and water every					
		Irainage bag below level					
	of bladder"						
	A facility policy	titled "Guidelines for					
	Urinary Catheter						
	1	Corporate RN on 6/17/11					
	^	uded, but was not limited					
	1 /	ary drainage bag should					
		oned lower than the					
	· •	nt the urine in the tubing					
	1 -	from flowing back into					
		ler11. Be sure the					
	catheter tubing a	nd drainage bag are kept					
	off the floor. 14.	Ensure the catheter					
	remains secured.	A leg strap may be used					
	to reduce friction	and movement at the					
	insertion site. (N	lote: Catheter tubing					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155661	B. WING		06/17/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L	ı	HWY 46	
	ALLEY HEALTH CA	AMPUS	SPEN	CER, IN47460	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
	* *	ed to the resident's inner			
	thigh.)"				
	3.1-41(a)(2)				
E0222	The facility must o	ensure that the resident			
F0323 SS=E		ins as free of accident			
33-L		sible; and each resident			
	•	supervision and assistance			
	devices to prevent				
	Based on observa	ation, interview and	F0323	what corrective actions will be	0//1//2011
	record review, th	e facility failed to ensure		accomplished for those reside found to have been affected	
	the residents' safe	ety for 4 of 7 residents		the deficient	Dy
	either utilizing m	nechanical lifts for		practice:ADHS/designee will	
	_	alarms to help prevent		re-educate CNA #'s 5, 6, 7, 8	
		of 21 in that lifts were		and 13 on proper procedure	
	not utilized per n			use of mechanical lift accord	ing
	*	and personal alarms		to manufacture guidelines	200
		correctly. (Resident #'s		(attachment #5). DHS/Desig will assess resident #60 for a	
	* *	CNA #'s 5, 6, 7, 8, 12,		reduction secondary to resid	
		CINA#53, U, 1, 0, 12,		disconnects alarm	
	13)			independently.Residents #'s	
				56, and 78 will be included in	
	Findings include	:		random audits(attachment # conducted by ADHS/Design	•
				times weekly x4 weeks to er	
		: 12:40 p.m., CNA #'s 12		transfer technique per	
		ed Resident # 78 from a		manufacturer's guidelines be	eing
	wheelchair to the	e bed utilizing a "Maxi		utilized.how other residents	
	Move" lift. Duri	ng the transfer, the CNAs		having the potential to be aff	
	kept the legs of t	he lift open wide, and		by the same deficient practice be identified and what correct the same deficient practice.	
		ng the bed, hit one leg on		actions will be taken:All resid	
	11			double will be taken, all resid	

141611

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIEF			920 W F	DDRESS, CITY, STATE, ZIP CODE HWY 46 ER, IN47460		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	legs on the whee	om and one of the lift el of the bed, causing the t was sitting in to swing			who utilize the mechanical litransfers and all residents wutilize bed and chair alarms safety have the potential to laffected by this alledgd defice practice, therefore through the systemic changes stated be thos residents will be ensure safe environment. What mean will be put into place or what systemic changes will be made ensure the deficient practice not recur: ADHS/Designee win-service (attachment #5) were turn demonstrations all nustaff on proper technique in the mechanical lift per manufacturer's guidelines. If the corrective actions will be monitored to ensure the deficient practice will not recur: All aud will be reviewed at monthly the meeting x 2 months or until compliance is achieved Manager/Designee will concrandom audits (attachment 2) three times weekly x 4 were on residents who utilize a bed/chair alarm to ensure all properly placed and functioning. Unit Manager/Designee will concrandom audits (attachment #6) three times a week x 4 were to ensure staff is following manufacturer's guidelines in transfering residents who utilize a three times and the safe proficient with the mechanical lift. ADHS/Designee will perform and annually to ensure all not safe proficient with the	tho for one cient he cient he cient he course to a does will with rising using the cient dits QA. Unit dits QA. Unit dict he ceks arm direct weeks	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

141611

Facility ID:

010892

If continuation sheet

Page 23 of 27

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		LDING	00	COMPL 06/17/2	ETED
	PROVIDER OR SUPPLIE		p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE HWY 46 ER, IN47460	1	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
TAG	2. On 6/14/11 at	3 p.m., Resident # 56 be transferred from the		TAG	mechanicalift per manufactu guidelines.	ırer's	DATE
	Move" mechanic #8. The resident	bed utilizing the "Maxi cal lift by CNAs #7 and t was observed to be lifted f the chair 18 inches. The					
	position through resident was 18	d in the high height out the transfer. The inches off the surface of or to being lowered. The					
	resident was at a chair level.	height above normal					
	#56 on 6/14/11 a most recent Min assessment was MDS identified	inical record of Resident at 2:40 p.m., indicated the imum Data Set (MDS) completed 5/8/11. The the resident as requiring					
	Nursing assessment indicated use of transfers.	nt of two for transfers. ent, dated 6/8/11, mechanical lift for					
	#6 were observe from the bed to Maxi Move med positioning the r resident was rais bed. The base o	11:30 a.m., CNAs #5 and d to transfer Resident #51 wheelchair with the Arjo hanical lift. After esident on the sling, the ed from the surface of the f the lift was observed					
	_	the lift in the closed dising the resident. The					

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155661	B. WIN			06/17/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OWEN V	ALLEY HEALTH CA	MDHS		1	HWY 46 ER, IN47460		
					ER, 11147400		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG		ere then opened and the	+	IAG			DATE
	_	lent was pulled away					
		ne resident was observed					
	-	osition, perpendicular to					
	· ·	s transferred across the					
		elchair. The resident was					
		sitting position, turned					
	·	and the base of the lift					
	*	d the wheelchair. The					
	resident was then	lowered into the chair.					
	Dazidant #511a al	::1					
		inical record was					
		7/11 at 4:10 p.m. The					
		um Data Set [MDS] with					
		ence date of 4/4/11,					
		nt as requiring total					
		for transfers and					
	non-ambulatory.						
	Davious of monut	footswarla amaratina and					
		facturer's operating and					
	-	ructions for the "ARJO					
	MAXI MOVE" t	•					
		vas noted, but not limited					
		sfer patients with the					
	_	e closed position					
		ng, position the patient to					
		t at approximately the					
	_	al chair. This provides a					
		dence and dignity to the					
	•	lowering the patient back					
		positioning handle to put					
		sitting position: This					
	avoids further lif	ting strain"					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155661	A. BUI	LDING	00	06/17/2011
		100001	B. WIN			00/17/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
OWEN V	ALLEY HEALTH CA	MPUS		1	HWY 46 ER, IN47460	
			_,		EIX, 1147 400	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
1110	REGULATORI OR	ESC IDENTIFICATION ORIGINAL	-	1710		DATE
	1 On 6/13/11 at	11:15 a.m., Resident # 60				
		have a personal pressure				
		ed. The alarm box was				
		ed frame within reach of				
	"	6/15/11 at 10:30 a.m.,				
		s observed lying in bed				
		al pressure alarm. The				
		oserved to be in reach of				
		6/15/11 at 2:55 p.m., the				
	alarm box was of	to the personal pressure				
		m the box and lying on				
		sident was observed in				
	the bed sleeping.	•				
		remained disconnected				
		ox and remained on the				
	floor.					
	During intervious	of LPN #11 on 6/15/11				
	_	se indicated the resident				
		se indicated the resident sected the alarm cord				
	^ -					
		he has a history of doing				
		king the sound of the				
	alarm.					
	Review of the ali	nical record of Resident				
		t 11:20 a.m., indicated				
		Minimum Data Set				
		nt was completed				
	· ′	essment identified the				
	l	g and short term memory				
	problem, and his	-				
	resident's most re	ecent fall was noted as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING 00 (X3) DATE SURVEY COMPLETED 06/17/2011		PLETED		
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460			
	SUMMARY S (EACH DEFICIEN REGULATORY OR 3/11/11. The resident's cu addressed the pre fall/injury as exh and potential for revised 4/11. The were not limited check placement Review of the "I Pad Alarm" on 6 indicated "Place the resident. Suit include: back of wheelchair, wall sure that the resi				SHOULD BE	(X5) COMPLETION DATE
	3.1-45(a)(2)					